Address (Number, Street, City, State, Zip) Phone No. Parent/Cuardian Names Where do you usually take your child for routine medical care?	Student's Name (Last, First, Middle)			Birthdate (Mo., Day, Yr.)	Sex (M/F)	Name of School	Grac
Where do you usually take your child for routine medical care? Name: When was the last time your child had a physical exam? Month Where do you usually take your child for dental care? Name: Address: Address: Phone No. Address: Address: Address: Address: Address: Address: Address: Phone No. Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Address: Ad							
Where do you usually take your child for or but in medical care? Name: Address: Phone No. Name: When was the last time your child for dental care? Name: Address: Phone No. *** Address: Phone No. *** Address: Phone No. *** SESSIMENT OF STUDENT HEALTH* *** To the best of your *** Color work of your **	Address (Number, Street, City, State, Zip)					Phone No.	
Name:	Parent/Guardian Names						
When was the last time your child had a physical exam? Month Year Where do you usually take your child for dental care? Address: Phone No. Name:		utine medic		ess:		Phone No.	
Name: Assessment of strubent Health To the best of your knowledge, has your child had any problem with the following? Please check Yes No Comments Anaphylaxis Allergies (Food, Insects, Drugs, Latex) Allergies (Seasonal) Asthma or Breathing Problems Behavior or Emotional Problems Behavior or Emotional Problems Birth Defects Birth Defects Cerebral Palsy Dental Diabetes Ear Problem or Deafness Eye or Vision Problems By or Vision Problems Head Injury Heart Problems Hospitalization (When, Where, Why) Lead Poisoning/Exposure Learning problems/disabilities Limits on Physical Activity Meningitis Prematurity Problem with Bladder Problem with Badder Problem with Bowels Problem with Bowels Problem with Goughing Seizures Serious Allergic Reactions Sickle Cell Disease Speech Problems Is your child on any special treatments? (nebulizer, epi-pen, etc.) No Yes Treatment_ Treatment_	When was the last time your child had a ph	ysical exam	? Month	Year			
ASSESSMENT OF STUDENT HEALTH To the best of your knowledge, has your child had any problem with the following? Please check Anaphylaxis Allergies (Food, Insects, Drugs, Latex) Allergies (Seasonal) Asthma or Breathing Problems Behavior or Emotional Problems Birth Defects Bleeding Problems Cerebral Palsy Dental Diabetes Ear Problem or Deafness Eye or Vision Problems Head Injury Heart Problems Head Injury Heart Problems Head Injury Heart Problems Heard Problems Froblem or Deafness Froblem or Deafness Froblem with Bladder Problem with Bladder Problem with Bowels Froblem with Bowels Froblem with Gughing Seizures Serious Allergic Reactions Sickle Cell Disease Speech Problems Is your child on any special treatments? (nebulizer, epi-pen, etc.) No Yes Treatment_		ntal care?				Phone No.	
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Heart Problems Hospitalization (When, Where, Why) Lead Poisoning/Exposure Learning problems/disabilities Limits on Physical Activity Meningitis Prematurity Problem with Bladder Problem with Bowels Problem with Coughing Seizures Serious Allergic Reactions Sickle Cell Disease Speech Problems Surgery Other Does your child take any medication?	Eye or Vision Problems						
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Learning problems/disabilities Limits on Physical Activity Meningitis Prematurity Problem with Bladder Problem with Bowels Problem with Coughing Seizures Serious Allergic Reactions Sickle Cell Disease Speech Problems Surgery Other Does your child take any medication?	Hospitalization (When, Where, Why)						
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Meningitis Prematurity Problem with Bladder Problem with Bowels Problem with Coughing Seizures Serious Allergic Reactions Sickle Cell Disease Speech Problems Surgery Other Does your child take any medication?	Limits on Physical Activity						
Prematurity Problem with Bladder Problem with Bowels Problem with Coughing Seizures Serious Allergic Reactions Sickle Cell Disease Speech Problems Surgery Other Does your child take any medication?	Meningitis						
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Serious Allergic Reactions Sickle Cell Disease Speech Problems Surgery Other Does your child take any medication?							
Sickle Cell Disease Speech Problems Surgery Other Does your child take any medication?							
Speech Problems Surgery Other Does your child take any medication?	_						
Surgery Other Does your child take any medication?							
Other Does your child take any medication?	-						
Does your child take any medication?							
Is your child on any special treatments? (nebulizer, epi-pen, etc.) No Yes Treatment		□ No □	Yes				
Treatment	Name(s) of Medications:						
	Is your child on any special treatments	? (nebulize	er, epi-pen,	etc.) 🗌 No 🔲 Ye	S		
Does your child require any special procedures? (catheterization, etc.) No Yes	Treatment						
	Does your child require any special pro	cedures? (catheteriza	tion, etc.) 🗌 No	□ Yes		
Parent/Guardian Signature Date	Parent/Guardian Signature					Data	

PART II SCHOOL HEALTH ASSESS To		pleted	ONLY by	Physician/Ni	urse Pra	actitioner		
Student's Name (Last, First, Middle)				Birthdate (Mo., Day, Yr.)	Sex (M/F)	Name of School		Grade
1. Does the child have a diagnosed medical	al conditio	n? □N	o □ Yes					
Specify								
2. Does the child have a health condition of an anaphylaxis to food or insect sting, asther please "work with the school nurse to describe the school nurse the school nurse to describe the school nurse the school n	ma, bleed evelop an	ing probl emergen	em, diabetes cy plan". [s, heart problem ☐ No ☐ Yes	he/she is , or other	at school? (e.g., seizure, severe alle problem) If yes, please DESCRIBE.	ergic read Addition	ction/ nally,
3. Are there any abnormal findings on eva] Yes				
Specify								
		EVALU	ATION FIN	IDINGS/CON	CERNS			
PHYSICAL EXAM	WNL	ABNL	Area of	HEALTH AR		CONCERN	Yes	No
Head	-		Concern	1				
Head	-					yperactivity		
Eyes ENT				Behavior/A Developme		nt		
Dental				Hearing	ent			
Respiratory				Immunode	ficiency			
Cardiac				Lead Expos		rated Lead		
GI	-			Learning D				
GU				Mobility	13abilitie	3/1100101113		
Musculoskeletal/Orthopedic				Nutrition				
Neurological				Physical Illr	ness/Imp	pairment		
Skin				Psychosoci				
Endocrine				Speech/Lar				
Psychosocial				Vision	<u> </u>			
,				Other				
REMARKS: (Please explain any abnormal street of the second of IMMUNIZATIONS: DHMI must be provided.					are provid	der or a computer generated immu	unization	record
5. Is the child on medication? If yes, indication	ite medica	ition and	diagnosis.	□ No □ Yes				
(A medication administration form must								
6. Should there be any restriction of physic	cal activity	in schoo	l? If yes, spe	cify nature and c	duration o	of restriction. □ No □ Yes		
7. Screenings Tuberculin Test	R	esults				Date Taken		
Blood Pressure								
Height								
Weight								
BMI %tile								
Lead Test	0	ntional						

PART II SCHOOL HEALTH ASSESSMENT (continued) To be completed ONLY by Physician/Nurse Practitioner							
(Child's Name)			has had a complete physical exa	amination and has:			
\square No evident problem that may affect learning or full school part	ticipation 🗌 F	roblems noted a	bove				
Additional Comments:							
Physician/Nurse Practitioner (Type or Print)	Phone No.	Physician/Nurse	e Practitioner Signature	Date			